SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201405605, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C, who works for a voluntary agency, complained on behalf of the family of Miss A. Miss A had suffered complex medical problems from birth. Mr C complained that Miss A had not been provided with appropriate care and treatment at the Southern General Hospital and Yorkhill Children's Hospital. He said the family believed there had been repeated failures by medical and nursing staff. They believed that they had not been communicated with appropriately and the board had failed to action their complaint in accordance with the NHS procedure. Miss A had had to undergo surgery on her windpipe and had multiple medical complications, which required on-going medical treatment.

We took independent advice from a consultant paediatrician and a paediatric nurse (specialists in the care of infants, children and young people). They concluded that the main failing on the part of the board was the failure to appoint a lead clinician to oversee Miss A's treatment. While we found that the clinical care and treatment provided to Miss A had been appropriate, this failure to appoint a lead clinician had contributed to the communication failures with the family. The nursing advice we received was that staff had not monitored Miss A's oxygen saturation levels appropriately and that the family had been forced to request that oxygen monitoring be provided.

We found that the board had failed to communicate adequately with the family and, although they had acknowledged this, we found that the board had provided no evidence to show that they had taken steps to avoid a reoccurrence. We also found that the board's response to the complaint had taken an unreasonable length of time and that the responses the family had received had been inaccurate.

We asked the board to apologise for their failings and take a number of actions to address them.

Recommendations

We recommended that the board:

- provide evidence that they have reviewed their oxygen saturation monitoring policy to ensure it corresponds with national guidance for children;
- review care planning for children with respiratory vulnerabilities to ensure that pulse oximetry values (used to measure the oxygen level of the blood) are monitored;
- review care planning to ensure that parental concerns for the child are recorded;
- remind the nursing staff involved in Miss A's care of the importance of comprehensive respiratory care plans to ensure less experienced staff are able to monitor patients effectively;
- provide evidence of the outcomes of the multi-disciplinary review considering continuity of care between acute and community services;
- provide evidence of the outcomes from the multi-disciplinary review of the allocation of lead-care coordinators;
- provide evidence of the changes made to the process for feeding back sleep study results to the parents

of children undergoing treatment;

- review their processes in relation to complaint handling of complex cases where more than one department is involved to ensure that a single clinical lead is appointed to oversee the response; and
- apologise for the failings we identified.